MDS 3.0: The Mini-series
Session #1

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MDS 3.0 – The Mini-series
Agenda – Session #1

- Welcome
- Chapter 2
- Section Z
- Section A
- Section S
- Section X

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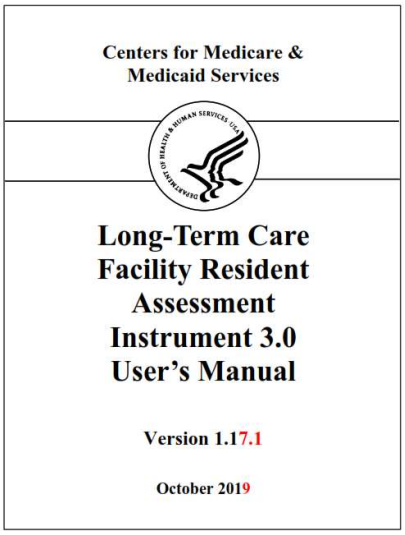

- Your first resource for information
- MDS Help Desk
- Case Mix Nurse
- State RAI Coordinator
- Other Resources?

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MDS 3.0 – The Mini-series Chapter 2

Long Term Care Facility
Resident Assessment Instrument (RAI)
User's Manual

Chapter 2

Effective Oct 2019

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MDS 3.0 – The Mini-series
Chapter 2

Federal Requirements for the MDS 3.0

- Initial and periodic assessments for **all** their residents residing in the facility for **14 or more days**.
- This includes hospice, respite, and special populations such as pediatric and psychiatric.

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Chapter 2

Responsibility of NF for Reproducing/Maintaining MDS 3.0

Federal regulatory requirements at 42CFR483.20(d) requires NF to maintain all resident assessments completed within the previous **15 months** in the resident's active clinical record following the completion date for all assessments and correction requests.

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Chapter 2

Responsibility of NF for Reproducing/Maintaining 3.0

Nursing Homes may:

1. Use electronic signatures for the MDS
2. Facilities must have written policies in place to ensure proper security measures are in place to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs
3. Maintain the MDS electronically
4. Maintain the MDS and Care Plans in a separate binder in a location that is *easily and readily accessible* to staff, surveyors, CMS etc.
5. In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (items V0200B-C), correction completion (items X1100A-E), and assessment completion (items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.

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Chapter 2

The Alphabet Soup of MDS

OBRA: Omnibus Budget Reconciliation Act
PPS: Prospective Payment System
ARD: Assessment Reference Date
PDPM: Patient Driven Payment Model
HIPPS: Health Insurance Prospective Payment System

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Chapter 2: Item Sets

There are 9 for Nursing Home providers as follows:

— **Comprehensive (NC^2) Item Set**
— **Quarterly (NQ) Item Set**
— **PPS (NP) Item Set**
— **Interim Payment Assessment (IPA)**
— **Discharge (ND) Item Set**
— **Part A PPS Discharge (NPE) Item Set**
— **Tracking (NT) Item Set**
— **Optional State Assessment (OSA)**
— **Inactivation (XX) Item Set**

The item set for a particular MDS record is completely determined by the Type of Provider, Item A0200 (indicating nursing home or swing bed), and the reason for assessment Items (A0310A, A0310B, and A0310H)

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Chapter 2: OBRA assessments

Below are the **OBRA** federally required assessments:

The assessments below will also be requiring PDPM items to calculate the PDPM HIPPS code for the following OBRA assessments:

- Admission
- Annual
- Significant Change
- Significant Correction to Prior Comprehensive
- Significant Correction to Prior Quarterly
- Quarterly
- Discharge Return Not Anticipated
- Discharge Return Anticipated

Entry Tracking Form
Death in Facility Tracking Form

These OBRA assessments do not PDPM item requirements.

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Chapter 2: PPS Assessments

Assessment Type/ Item Set for PPS	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Billing Cycle Used by the Business Office	Special Comment
5-Day A0310B = 01	Days 1-8	Sets payment rate for the entire stay (unless an IPA is completed. See below.)	• See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the 5-Day assessment is dually coded as an OBRA Admission, Annual, SCSA or SCPA.
Interim Payment Assessment (IPA) A0310B = 08	Optional	Sets payment for remainder of the stay beginning on the ARD.	• Optional assessment. • Does not reset variable per diem adjustment schedule. • May not be combined with another assessment.
Part A PPS Discharge Assessment A0310H = 1	End date of most recent Medicare Stay (A2400C)	N/A	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or can be combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

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Chapter 2

Item Sets by Assessment Type for Skilled Nursing Facilities

	Comprehensive Item Sets	Quarterly and PPS* Item Sets	Other Assessments and Tracking Records/Item Sets
Standalone Assessment Types	• OBRA Admission • Annual • Significant Change in Status (SCSA) • Significant Correction to Prior Comprehensive (SCPA)	• Quarterly • Significant Correction to Prior Quarterly • 5-Day	• Entry Tracking Record • OBRA Discharge assessments • Death in Facility Tracking Record • Part A PPS Discharge • Interim Payment Assessment (IPA)
Combined Assessment Types	• OBRA Admission and 5-Day • Annual and 5-Day • SCSA and 5-Day • SCPA and 5-Day • Any OBRA comprehensive and any Discharge	• Quarterly and 5-Day • Significant Correction to Prior Quarterly and 5-Day • 5-Day and any Discharge • Significant Correction to Prior Quarterly and any Discharge	• OBRA Discharge assessment and Part A PPS Discharge Assessment

Care Area Assessment Process and care plan process remains the same.
Note: Standalone OBRA assessments will require completion PDPM items required to calculate the PDPM HIPPA codes.

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2.12 Factors Impacting SNF PPS Assessment Scheduling.

- Resident is Admitted to an Acute Care Facility and Returns:
  - A new 5-Day assessment is required, *unless it is an instance of an interrupted stay.*
  - *If it is a case of an interrupted stay (i.e., the resident returns to the SNF and resumes Part A services in the same SNF within the 3-day interruption window), then no PPS assessment is required upon reentry, only an Entry tracking form.*
    - *An IPA may be completed, if deemed appropriate.*

- Resident Is Sent to Acute Care Facility, Not in SNF over Midnight and is Not Admitted to Acute Care Facility:
  - If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted to an acute care facility, *a new 5-day PPS assessment is not required, though an IPA may be completed, if deemed appropriate.*
  - Payment implications: The day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day pursuant to the "midnight rule."

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- Resident Takes a Leave of Absence from the SNF:
  - If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2–13 in this chapter, *there may be payment implications*.
  - For example, if a resident leaves a SNF at 6 p.m. on Wednesday, which is Day 27 of the resident's stay, and returns to the SNF on Thursday at 9 a.m., then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay.

- Resident Discharged from Part A Skilled Services and From the Facility and Returns to SNF Part A Skilled Level Services:
  - In the situation when a beneficiary is discharged from Medicare Part A and is physically discharged from the facility but returns to resume SNF Part A skilled services after the interruption window has closed, the OBRA Discharge and Part A PPS Discharge must be completed and may be combined.

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MDS 3.0 – SNF/NF Chapter 2

- On return to the facility, this is considered a new Part A stay (as long as resumption of Part A occurs within the 30-day window allowed by Medicare), and a new 5-Day and Entry Tracking Record must be completed. If the resident was discharged return not anticipated, the facility must also complete a new OBRA Admission assessment.
- In the case of an interrupted stay, only an OBRA Discharge is required. An Entry Tracking Record is required on reentry, but no 5-Day is required. If the resident was discharged return anticipated, no OBRA assessment is required. However, if the resident was discharged return not anticipated, the facility must complete a new OBRA Admission assessment.

• Resident Discharged from Part A Skilled Services Is Not Physically Discharged from the Skilled Nursing Facility

- In the situation when a resident's Medicare Part A stay ends, but the resident is not physically discharged from the facility, remaining in a Medicare and/or Medicaid certified bed with another payer source, the facility must continue with the OBRA schedule from the beneficiary's original date of admission (item *A1900*) and must also complete a Part A PPS Discharge assessment.

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MDS 3.0 – SNF/NF Chapter 2

- If the Part A benefits resume, there is no reason to change the OBRA schedule; the *PPS* schedule would start again with a 5-*D*ay assessment, MDS *item* A0310B = 01, ***unless*** *it is a case of an interrupted stay – that is, if the resident is discharged from Part A, remains in the facility and resumes Part A within the 3-day interruption window, no PPS Discharge is completed, nor is a 5-Day required when Part A resumes.*

• Non-Compliance with the PPS Assessment Schedule:

- Frequent late assessment scheduling practices *or missed assessments* may result in *additional* review.
- The default rate takes the place of the otherwise applicable Federal rate.
- This rate is equal to the rate paid for the *Health Insurance Prospective Payment System (HIPPS) code* reflecting the lowest acuity level *for each PDPM component*, and be lower than the Medicare rate payable if the SNF had submitted an assessment on time.

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- Late PPS Assessment:
  - *The* SNF will bill the default rate for the number of days that the assessment is out of compliance.
  - This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD).
  - **The SNF would then bill the HIPPS code established by the late assessment for the *remainder of the SNF stay, unless the SNF chooses to complete an IPA*.**

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MDS 3.0

Long Term Care Facility
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Section Z

Section Z

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

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Section Z

Section Z	Assessment Administration
Z0100. Medicare Part A Billing	
	A. Medicare Part A HIPPS code: ☐☐☐☐☐☐☐
	B. Version code: ☐☐☐☐☐☐☐☐☐☐
Z0200. State Medicaid Billing (if required by the state)	
	A. Case Mix group: ☐☐☐☐☐☐☐☐☐☐
	B. Version code: ☐☐☐☐☐☐☐☐☐☐
Z0250. Alternate State Medicaid Billing (if required by the state)	
	A. Case Mix group: ☐☐☐☐☐☐☐☐☐☐
	B. Version code: ☐☐☐☐☐☐☐☐☐☐

To check your final validation report:
https://sms.muskie.usm.maine.edu/

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Section Z

Z0400 Attestation Statement

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

Month – Day – Year

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Section Z

Z0400 Signature of Persons Completing the Assessment or Entry/Death Reporting.

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. ***I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.*** I also certify that I am authorized to submit this information by this facility on its behalf.

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Section Z

Z0400 Attestation Statement

Coding Instructions

- All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.

- If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.

- Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

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MDS 3.0 Training
Payment Items and Documentation

Z0500 Assessment Complete

Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete

- ✓ Verify that all items on this assessment or tracking record are complete.
- ✓ Verify that Item Z0400 contains attestation for <u>all</u> MDS sections.

Use the actual date that the MDS was completed, reviewed, and signed as complete by the Registered Nurse (RN) assessment coordinator. *This date must be equal to the latest date at Z0400 or later than the date(s) at Z0400*, which documents when portions of the assessment information were completed by assessment team members.

If the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.

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FYI…

Chapter 110, Regulations Governing the Licensing and Function of Skilled Nursing Facilities and Nursing Facilities

http://www.maine.gov/sos/cec/rules/10/ch110.htm

Chapter 2.B.1.b Comprehensive Assessment (page 2)

b. Each individual who completes a portion of the assessment *must* sign and certify the accuracy of that portion of the assessment.

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MDS 3.0 – SNF/NF
Section A

Section A
Identification Information

Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

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Section A

A0050 - Type of Record

- Code 1 for a **new record** that has not been previously submitted and accepted in the QIES ASAP system
- Code 2 to **modify** the MDS items for a record that has been submitted and accepted in the QIES ASAP system
- Code 3 to **inactivate** a record that already has been submitted and accepted in the QIES ASAP system

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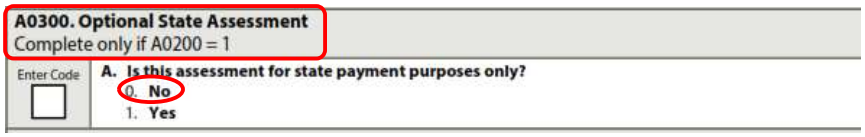
MDS 3.0 – SNF/NF
Section A

Abbreviations have now been spelled out for the first use, i.e. Quality Improvement Evaluations System (QIES) Assessment Submission and Processing (ASAP)

A0100 Facility Provider Numbers

Coding Instructions:

B. CMS Certification Number (CCN) – If A0410 = 3 (federal required submission), then A0100B (facility CCN) must not be blank.



Maine will **NOT** be using the OSA for payment purposes. OBRA comprehensive and quarterly assessments will continue to be used for payment purposes using RUG III payment groups for now. The payment methodology will be changing in the future.

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Section A

A0310 Purpose

- Documents the reason for completing the assessment
- Identifies the required assessment content information (**determines item set**)
- There are several subsections to A0310

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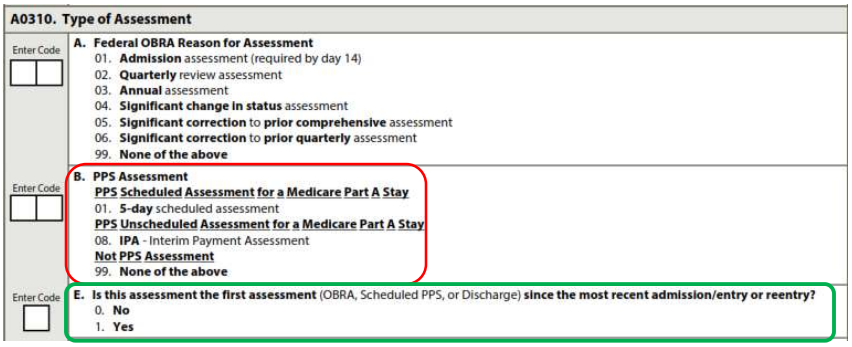
MDS 3.0 – SNF/NF
Section A



A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code

B. PPS Assessment
PPS Scheduled Assessment for a Medicare Part A Stay
01. **5-day** scheduled assessment
PPS Unscheduled Assessment for a Medicare Part A Stay
08. **IPA** - Interim Payment Assessment
Not PPS Assessment
99. **None of the above**

Enter Code

E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**
0. **No**
1. **Yes**

Significant change is an OBRA assessment only. It could be combined with an Interim Payment Assessment (IPA), as appropriate.

A0310E = 0 (meaning "no") for all tracking record and an Interim Payment Assessment (A0310A = 99, A0310B = 08, A0310F = 99, and A0310H=0).

Assessment means OBRA, Scheduled PPS, or Discharge

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Section A

Significant Change Criteria

A **"significant change"** is a decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only);
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

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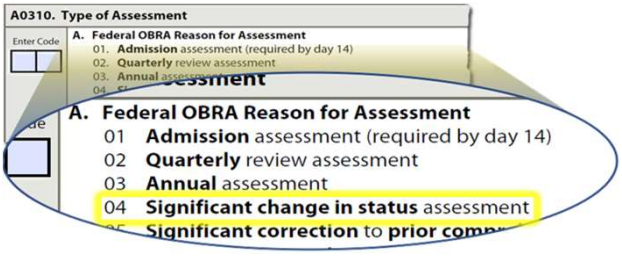
Section A

A0310A Hospice Benefit

- Electing or revoking the hospice benefit requires a significant change in status assessment
- Change in hospice provider requires a significant change in status assessment
- ARD must be within 14 days of the effective date of hospice election.



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Section A

Significant Error

A **"significant error"** is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

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Section A

Coding Section A : A0310F Entry/ Discharge Reporting

01. Entry tracking record
10. Discharge assessment – **return *not* anticipated**
11. Discharge assessment – **return anticipated**
12. Death in facility tracking record
99. None of the above

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Section A

Coding A0310G: Type of Discharge

Coding Instructions (complete only if A0310F = 10 or 11)

Enter the number corresponding to the type of discharge.
- Code 1: if type of discharge is a *planned* discharge.
- Code 2: if type of discharge is an unplanned discharge.

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MDS 3.0 – SNF/NF
Section A

Enter Code	G1. Is this a SNF Part A Interrupted Stay?
☐	0. No 1. Yes

Interruption Window
Is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the ***same*** *SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.*

Interrupted Stay
Is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the ***same*** *SNF for a Medicare Part A-covered stay during the interruption window.*

Code 0, no: if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but did not resume SNF care in the same SNF within the interruption window.

Code 1, yes: if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) Is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the same SNF for a but did resume SNF care in the same SNF within the interruption window.

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MDS 3.0 – SNF/NF
Section A – Interrupted Stay

The following is a list of examples of an interrupted stay when the resident leaves the SNF and then returns to the same SNF to resume Part A-covered services within the interruption window. Examples include, but are not limited to, the following:

- Resident transfers to an acute care setting for evaluation or treatment due to a change in condition and returns to the same SNF within the interruption window.
- Resident transfers to a psychiatric facility for evaluation or treatment and returns to the same SNF within the interruption window.
- Resident transfers to an outpatient facility for a procedure or treatment and returns to the same SNF within the interruption window.
- Resident transfers to an assisted living facility or a private residence with home health services and returns to the same SNF within the interruption window.
- Resident leaves against medical advice and returns to the same SNF within the interruption window.

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MDS 3.0 – SNF/NF
Section A

The following is a list of examples of an interrupted stay when the resident under a Part A-covered stay remains in the facility but the stay stops being covered under the Part A PPS benefit, and then resumes Part A-covered services in the SNF within the interruption window. Examples include, but are not limited to, the following:

- Resident elects the hospice benefit, thereby declining the SNF benefit, and then revokes the hospice benefit and resumes SNF-level care within the interruption window.
- Resident refuses to participate in rehabilitation and has no other daily skilled need; this ends the Part A coverage. Within the interruption window, the resident decides to engage in the planned rehabilitation regime and Part A coverage resumes.
- Resident changes payer sources from Medicare Part A to an alternate payer source (i.e., hospice, private pay or private insurance) and then wishes to resume their Medicare Part A stay, at the same SNF, within the interruption window.

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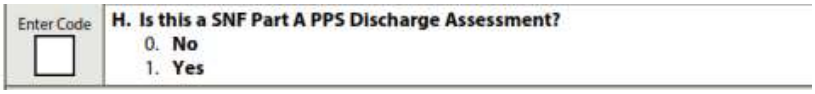
Section A

A0310H SNF Part A PPS Discharge



Part A PPS Discharge Assessment:

- Completed when a resident's *Medicare Part A stay ends (A2400C)*, and the resident remains in the facility;

or

- May be combined with an OBRA Discharge (A0310F = 10) if the Part A stay ends on the same day or the day before the resident's discharge date (A2000). (Page A-11)

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Section A

Discharge from facility and Part A:

Combined OBRA/Part A discharge MDS.

*If the end date of the most recent Medicare stay (**A2400C**) occurs **on the day of or one day before** the Discharge Date (**A2000**) of a **planned discharge** (**A0310G=1**), the OBRA Discharge assessment* and *Part A PPS Discharge assessment are both required and may be combined.*

*When the OBRA and Part A PPS Discharge assessments are **combined**, the ARD (**A2300**) must be equal to the Discharge Date (**A2000**).*

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If the resident is **remaining** in the facility:

F. Entry/discharge reporting
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

G. Type of discharge - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

G1. Is this a SNF Part A Interrupted Stay?
0. **No**
1. **Yes**

H. Is this a SNF Part A PPS Discharge Assessment?
0. **No**
1. **Yes**

- A0310F will be coded as '**99**', as this is not an OBRA discharge →
- Therefore, A0310G will be skipped, as this is completed only if A0310F = 10 or 11 →
- A0310H will be coded '**Yes,**' for a Part A PPS discharge

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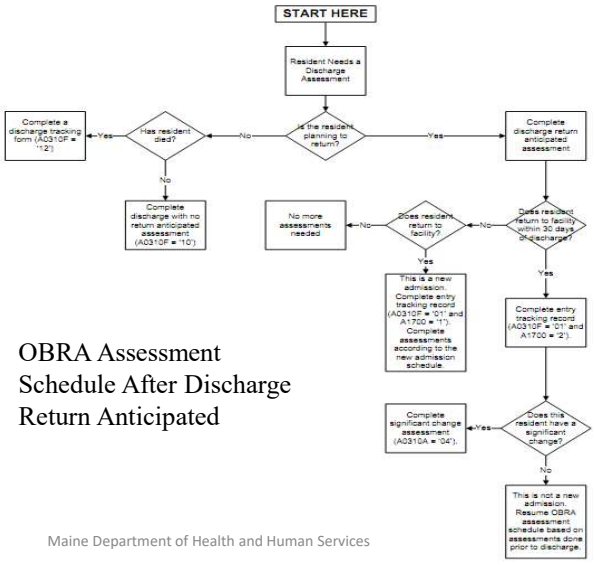
MDS 3.0 – The Mini-series Section A



OBRA Assessment Schedule After Discharge Return Anticipated

No new OBRA admission assessment required after *re-admission* from hospital. Submit entry tracking form and continue previously established OBRA schedule, or complete a significant change as appropriate.

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Section A

A0410. Unit Certification or Licensure Designation

A0410. Unit Certification or Licensure Designation	
Enter Code ☐	1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 3. Unit is Medicare and/or Medicaid certified

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MDS 3.0 – SNF/NF
Section A

A0600. Social Security and Medicare Numbers	
	A. Social Security Number: ☐☐☐-☐☐-☐☐☐☐ B. Medicare number: ☐☐☐☐☐☐☐☐☐☐☐☐

Coding Instructions amended to include a note:

- *A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible.*

- Coding instructions updated:
  - For PPS assessments (A0310B = 01 *or 08*), the Medicare number (A0600B) must be present (i.e., may not be left blank).
  - A0600B *must* be a Medicare number.
- Definition updated to state that it is different from the SSN and may contain both letters and numbers.

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MDS 3.0 – The Mini-series
Section A

Section A: Resident Data

A0500 through A1300

Check and double check the accuracy of the name and all numbers – social security, Medicare and MaineCare numbers, date of birth.

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MDS 3.0 – The Mini-series
Section A

PASRR/ Medicaid

All individuals admitted to Medicaid certified NFs, regardless of payment source must have a Level I PASRR (federal requirement)

If the Level I screen is positive for known or suspected mental illness, intellectual disability, developmental disability, or "other related conditions," a Level II evaluation is performed.

A1500 is completed only if A0310A = 01, 03, 04, or 05 (comprehensive assessments)

This item is asking specifically about PASRR Level II: Is the resident considered to *have* a serious mental illness and/or intellectual disability or a related condition

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MDS 3.0 – The Mini-series
Section A

Section A : A1510- Level II Preadmission Screening and Resident Review (PASRR) Conditions

Completed only if admission (01), Annual (03), significant change (04), or significant correction to prior comprehensive assessment (05)

Level II conditions:

- Serious mental illness
- Intellectual disability
- Other related condition

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MDS 3.0 – The Mini-series
Section A

Section A: A1550- Level II Preadmission Screening and Resident Review (PASRR) Conditions

A1550. Conditions Related to ID/DD Status
If the resident is 22 years of age or older, complete only if A0310A = 01
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05
↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

	ID/DD With Organic Condition
☐	A. Down syndrome
☐	B. Autism
☐	C. Epilepsy
☐	D. Other organic condition related to ID/DD
	ID/DD Without Organic Condition
☐	E. ID/DD with no organic condition
	No ID/DD
☐	Z. None of the above

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MDS 3.0 – The Mini-series
Section A

PASRR

https://www.ascendami.com/ami/Providers/YourState/MaineASAUserTools.aspx

MAXIMUS

Effective October 1, 2018, Maximus now processes the assessments that were formerly done by KEPRO. The full name of Maximus is "Ascend Management Innovations."

Maximus will perform the standardized assessments that determine eligibility and communicate service options to individuals seeking State-funded and MaineCare program Long-Term Care (LTC) services. In addition, ASA assessors conduct Preadmission Screening and Resident Review (PASRR) assessments for individuals suspected of having a mental disorder, intellectual disability, or other related condition to determine the LOC services required.

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MaineCare members can reach Maximus by phone at 833-525-5784 or email at ask-Maineasa@maximus.com.

Maine Department of Health and Human Services

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MDS 3.0 – The Mini-series
Section A

A1600-A1800 Most Recent Admission/Entry or Reentry to the facility

A1900 Admission Date

A2000 Discharge Date

A2100 Discharge Status

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Maine Department of Health and Human Services

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MDS 3.0 – The Mini-series
Section A

Section A: A2300 Assessment Reference Date (ARD)

ASSESSMENT REFERENCE DATE (ARD) The specific end-point for the look-back periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the Assessment Reference Date (ARD). Most frequently, this look-back period, also called the observation or assessment period, is a 7-day period ending on the ARD. Look-back periods may Coding Tips and Special Populations When the resident dies or is discharged prior to the end cover the 7 days ending on this date, 14 days ending on this date, etc.

Anything that happens after the ARD will not be captured on that MDS.

The look-back period includes observations and events through the end of the day (11:59 PM) of the ARD.

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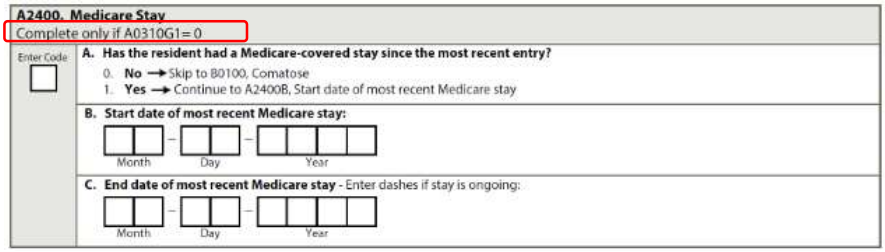
MDS 3.0 – SNF/NF
Section A



A2400. Medicare Stay
Complete only if A0310G1=0

Enter Code

A. Has the resident had a Medicare-covered stay since the most recent entry?
0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:
Month – Day – Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:
Month – Day – Year

When a resident on Medicare Part A has an interrupted stay (i.e., is discharged from SNF care and subsequently readmitted to the same SNF within the interruption window after the discharge), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.

Items A2400A–A2400C are not active when the OBRA discharge assessment indicates the resident has had an interrupted stay (A0310G1=1).

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MDS 3.0 – The Mini-series
Section S

Section S

This section is specific data requirements for the State of Maine only.

S0120 Residence Prior to Admission

Enter the zip code of the community address where the resident last resided prior to nursing facility admission.

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MDS 3.0 – The Mini-series
Section S

S0170. Advanced Directive

A.	Guardian
B.	Durable power of attorney for health care
C.	Living will
D.	Do not resuscitate
E.	Do not hospitalize
F.	Do not intubate
G.	Feeding restrictions
H.	Other treatment restrictions
Z.	None of the above

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MDS 3.0 – The Mini-series
Section S

S0510. PASRR Level I Screening

Was a PASRR Level I screening completed?

0. No → Skip to S3300 Weight-based Equipment Needed
1. Yes → Continue to S0511 PASRR Date
9. Unknown → Skip to S3300 Weight-based Equipment Needed

Note the skip patterns

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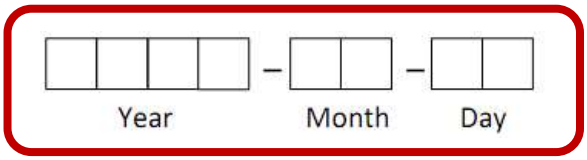
MDS 3.0 – The Mini-series
Section S

S0511. PASRR Level I Date: (Complete only if S0510 = 1)



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MDS 3.0 – The Mini-series
Section S

S0513. PASRR Level I Screening Outcome

What was the outcome of the PASRR Level I screen?

0. Screen was sent to the NF; no diagnosis, suspected diagnosis or need for specialized services
1. Screen was sent for determination of need for Level II screen due to diagnosis, suspected diagnosis or need for specialized services related to mental illness, intellectual disability, or other related condition

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MDS 3.0 – The Mini-series
Section S

S3300. Weight-based Equipment Need

Did this resident require specialized equipment based on weight since last assessment?

0. No → Skip to S6020 Specialized Needs
1. Yes → Continue to S3305 Requirements for Weight

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MDS 3.0 – The Mini-series
Section S

S3305. Requirements for Care, *Specifically related to Weight*

A.	**Lifting device.** Since last assessment, was a specialized lifting device required?
B.	**Wheelchair or mobility device.** Since last assessment, was an oversized, non-standard wheelchair or other mobility device required?
C.	**Bed.** Since last assessment, was a specialized, non-standard bed required?
D.	**Seating.** Since last assessment, was a specialized, non-standard seat required?
E.	**More than 2 staff.** Since last assessment, was 3 or more staff required to provide assistance with ADL?
Y.	**Other.** Since last assessment, was other specialized, non-standard equipment required? ☐

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MDS 3.0 – The Mini-series
Section S

S6020. Specialized needs specifically related to a resident's need for a Ventilator/Respirator

A.	**RN expertise.** Resident needs care by an RN with specialized expertise.
B.	**CNA training.** Resident needs care by CNA staff with specialized training.
C.	**Therapy (PT, OT, RT) expertise.** Resident needs therapy (PT, OT, RT) with specialized training or expertise.
D.	**Equipment.** Resident needs specialized equipment.
Y.	**Other.** Resident has other needs. ☐
Z.	**None of the above**

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MDS 3.0 – The Mini-series
Section S

S8010 Payment Source – To determine payment source that covers the *daily per diem* or ancillary services for the resident's stay in the nursing facility, **as of the ARD date**.

- C3 – MaineCare per diem. Do not check if MaineCare is pending
- G3 – MaineCare pays Medicare or insurance co-pay

S8099 None of the above

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MDS 3.0 – The Mini-series
Section X

Section X: Correction Request

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. Section X is only completed if Item A0050, Type of Record, is coded a 2 (***Modify*** existing record) or a 3 (***Inactivate*** existing record).

In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

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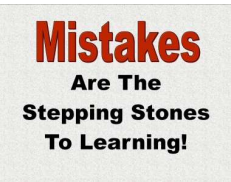
MDS 3.0 – The Mini-series
Section X

Section X: Correction Request

A **modification** request is used to correct a QIES ASAP record containing incorrect MDS item values due to:

- Transcription errors
- Data entry errors
- Software product errors
- Item coding errors, and/or
- Other error requiring modification



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MDS 3.0 – The Mini-series
Section X

Section X: Correction Request

An inactivation request is used to move an existing record in the QIES ASAP database from the active file to an archive (history file) *so that it will not be used for reporting purposes*.

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MDS 3.0 – The Mini-series
Section X

Section X: Correction Request: Manual Deletion

A Manual Deletion Request is required **only in the following four cases:**

1. Item A0410 Submission Requirement is incorrect.
2. Inappropriate submission of a test record as a production record.
3. Record was submitted for the wrong facility.
4. Information submitted to CMS in error, such as submitting a 5-day for a resident with Medicare managed care as a payer.

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MDS 3.0 – The Mini-series
Section X

Section X: Correction Request

X0150 Type of Provider
X0200 Name of Resident
X0300 Gender
X0400 Date of Birth
X0500 Social Security Number
X0570 Optional State Assessment (No)
X0600 Type of Assessment (matches choices at A0310A, B, F, and H)
X0700 Date on existing record (complete one choice only)

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MDS 3.0 – The Mini-series
Section X

Section X: Correction Request

X0800: Correction number
X0900: Reasons for Modification, (If A0050 = 2)
X1050: Reasons for Inactivation, (If A0050 =3)
X1100: Name, Title, Signature, Attestation Date

Do *not* change the Assessment Reference Date (ARD) as it will change the look back periods for the entire assessment

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MDS 3.0 – The Mini-series
Session #1

Questions?

Forum call for Nursing Facilities
1st Thursday of the month in February, May, August and November, 1:00-2:00

Call the MDS Help Desk to register!

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MDS 3.0 – The Mini-series Session #1

Reminders!

- This completes *Session 1* of the MDS 3.0 training. Thank you for attending.
- Ask questions!
- Ask more question!!
- Use your resources (other MDS coordinators, case mix staff, MDS Help Desk, Forum Calls etc.)
- Attend training as often as you need.

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MDS 3.0 – The Mini-series Session #1

Contact Information:

- **MDS Help Desk**: 624-4095 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
- **Lois Bourque, RN**: 592-5909
  Lois.Bourque@maine.gov
- **Deb Poland, RN, RAC-CT**: 215-9675
  Debra.Poland@maine.gov
- **Christina Stadig RN, RAC-CT:** 446-3748
  Christina.Stadig@maine.gov
- **Emma Boucher RN, RAC-CT**: 446-2701
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- **Sue Pinette, RN, RAC-CT**: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

Training Portal: www.maine.gov/dhhs/dlrs/mds/training/

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Questions?

Sue Pinette RN, RAC-CT
Case Mix Manager, State RAI Coordinator
(207) 287-3933

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